

Abbreviated Donor History Questionnaire

Date of Last Donation:		
	Yes	No
1. Are you feeling healthy and well today?	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you read the educational materials?	<input type="checkbox"/>	<input type="checkbox"/>
In the past 48 hours		
3. Have you taken aspirin or anything that has aspirin in it?	<input type="checkbox"/>	<input type="checkbox"/>
In the past 6 weeks		
4. Female donors: Have you been pregnant or are you pregnant now? (Males: check "I am male.")	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> I am male		
In the past 8 weeks have you		
5. Donated blood, platelets or plasma?	<input type="checkbox"/>	<input type="checkbox"/>
6. Had any vaccinations or other shots?	<input type="checkbox"/>	<input type="checkbox"/>
7. Had contact with someone who had a smallpox vaccination?	<input type="checkbox"/>	<input type="checkbox"/>
In the past 16 weeks		
8. Have you donated a double unit of red cells using an apheresis machine?	<input type="checkbox"/>	<input type="checkbox"/>
Since your last donation have you		
9. Had any new medical problems or diagnoses?	<input type="checkbox"/>	<input type="checkbox"/>
10. Had any new medical treatments?	<input type="checkbox"/>	<input type="checkbox"/>
11. Taken any of the medications on the Medication Deferral List?	<input type="checkbox"/>	<input type="checkbox"/>
12. Been outside the United States or Canada?	<input type="checkbox"/>	<input type="checkbox"/>
13. Come into contact with someone else's blood?	<input type="checkbox"/>	<input type="checkbox"/>
14. Had an accidental needle-stick?	<input type="checkbox"/>	<input type="checkbox"/>
15. Had sexual contact with anyone who has HIV/AIDS or has had a positive test for the HIV/AIDS virus?	<input type="checkbox"/>	<input type="checkbox"/>
16. Had sexual contact with a prostitute or anyone else who takes money or drugs or other payment for sex?	<input type="checkbox"/>	<input type="checkbox"/>
17. Had sexual contact with anyone who has ever used needles to take drugs or steroids, or anything <u>not</u> prescribed by their doctor?	<input type="checkbox"/>	<input type="checkbox"/>
18. Had sexual contact with anyone who has hemophilia or has used clotting factor concentrates?	<input type="checkbox"/>	<input type="checkbox"/>
19. Female donors: had sexual contact with a male who has ever had sexual contact with another male? (Males: check "I am male.")	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> I am male		
20. Had sexual contact with anyone who was born in or lived in Africa?	<input type="checkbox"/>	<input type="checkbox"/>
21. Had sexual contact with a person who has hepatitis?	<input type="checkbox"/>	<input type="checkbox"/>
22. Lived with a person who has hepatitis?	<input type="checkbox"/>	<input type="checkbox"/>
23. Received money, drugs, or other payment for sex?	<input type="checkbox"/>	<input type="checkbox"/>
24. Male donors: had sexual contact with another male, even once? (Females: check "I am female.")	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> I am female		
25. Had a tattoo?	<input type="checkbox"/>	<input type="checkbox"/>
26. Had ear or body piercing?	<input type="checkbox"/>	<input type="checkbox"/>
27. Been in juvenile detention, lockup, jail, or prison for more than 72 hours?	<input type="checkbox"/>	<input type="checkbox"/>
28. Used needles to take drugs, steroids, or anything <u>not</u> prescribed by your doctor?	<input type="checkbox"/>	<input type="checkbox"/>
29. Have any of your relatives had Creutzfeldt-Jakob disease?	<input type="checkbox"/>	<input type="checkbox"/>
30. From 1980 to the present , did you receive a blood transfusion in the United Kingdom or France? (Review list of countries in the UK.)	<input type="checkbox"/>	<input type="checkbox"/>

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